



STATE OF CONNECTICUT  
 Department of Consumer Protection  
 COMMISSION OF PHARMACY  
 165 Capitol Avenue, Room 147  
 Hartford, CT 06106  
 Telephone: (860) 713-6070  
 Web Site: [www.ct.gov/dcp](http://www.ct.gov/dcp)

## APPLICATION FOR LICENSURE AS A PHARMACIST BY EXAMINATION

This application should be completed and returned with payment to:  
**DCP, License Services Division, 165 Capitol Ave., Hartford, CT 06106**

### • Section I: Examination

Please "CHECK" the box on the left below:

<b>Connecticut Calculations &amp; Pharmacy Practice</b>	<input type="checkbox"/> I am applying for licensure as a pharmacist in the State of CT and am submitting a check/money order <b>for \$250.00</b> for this purpose, made payable to <b>'Treasurer, State of CT'</b> .
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**DEADLINES:** The Commission of Pharmacy **must** receive your application by **December 1<sup>st</sup>** for the **January Examination** & by **May 1<sup>st</sup>** for the **June Examination** (The Commission of Pharmacy will not accept applications received after the deadline date even if postmarked before the deadline date.) ***NO EXCEPTIONS CAN BE MADE***

**IMPORTANT NOTICE:** You are required to pass both the **NAPLEX** and **MPJE** (for CT) Exams that are administered through the **National Association of Boards of Pharmacy**, in addition to the exams for which you are presently applying, before you can be licensed as a pharmacist in CT.

### • Section II: Personal information

Name of Applicant (First, Middle, Last)		Social Security No.:
Home Address (No. & Street, City, State, Zip Code)		Tel Number (w/area code)
Date of birth (Month/day/yr)	Place of birth (City & State)	

• **Section III: Pharmacy Education**

Colleges Attended

Dates attended

College name	From	To
College name	From	To
College name	From	To

I was granted a diploma of graduation from (Name of college) \_\_\_\_\_  
on the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, and received the degree of: \_\_\_\_\_  
(Month) (Year) (Type of Degree)

• **Section IV: Practical Experience/Intern Registration**

I have a total of (number) \_\_\_\_\_ hours of practical experience on file with the (State) \_\_\_\_\_ Board of Pharmacy.

Please check the appropriate statement(s):

☐ My internship hours are on file with the Connecticut Commission of Pharmacy since I hold a pharmacy intern registration issued by the State of Connecticut.

Registration number	Date of issue	Expiration date
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☐ My internship hours are not on file with the Connecticut Commission of Pharmacy and **I will request that my State Board of Pharmacy or College of Pharmacy send the hours directly to the Connecticut Commission of Pharmacy.**

• **Section V: Previous Licensure as a Pharmacist**

If you have previously been licensed as a pharmacist in this state or any other state please complete the following:

Name of State	Date(s) issued: (month/yr)	License number	Good standing <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of State	Date(s) issued: (month/yr)	License number	Good standing <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of State	Date(s) issued: (month/yr)	License number	Good standing <input type="checkbox"/> Yes <input type="checkbox"/> No

• **Section VI: Additional Qualifications**

- ♦ I will be 18 years of age at the anticipated time of my licensure in CT as required by law: ☐ **Yes** ☐ **No**
- ♦ I have submitted a recent photograph of myself (no less than 2" x 3", frontal view) and I have signed it on the front or back as required by the Commission ☐ **Yes** ☐ **No**

• **Section VII: Certification**

*I CERTIFY, UNDER PENALTY OF LAW THAT THE INFORMATION PROVIDED IN THIS APPLICATION IS THE TRUE TO THE BEST OF MY KNOWLEDGE.*

Signature:

Date:

• **Section VIII: Affidavit of Educational Institution**  
***To be completed by school or college of pharmacy***

For Graduates of an Accredited College of Pharmacy Only

This is to certify that (student's name) \_\_\_\_\_ has attended the  
\_\_\_\_\_ from \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_  
Name of College of Pharmacy Mo. Day Yr. Mo. Day Yr.  
Date (or expected) of Graduation: \_\_\_\_\_ Degree (to be) received: \_\_\_\_\_

Certified By: \_\_\_\_\_  
Print Name of Dean/Registrar Signature Dean/Registrar

School Seal: (apply here)

